The United States Children’s Bureau and Pediatric Medicine: A Retrospective Analysis

This year marks the centennial of the founding of the United States Children’s Bureau. A remarkable agency, directed by women in its early years, the bureau played a major role in studying and lowering infant mortality. Medical historians Janet Golden and Jeffrey Brosco provide an overview of its history, and of why it had an oftentimes stormy relationship with organized medicine, sometimes including pediatrics.

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This year, 2012, marks the 100th anniversary of the United States Children’s Bureau, a federal agency founded with the support of pediatricians. Its history, including its conflicts with organized medicine and its path-breaking work in promoting child health, is helpful in understanding the new focus in pediatrics on the social determinants of health from a life-course perspective.

A December 1912 New York Times article headlined “150,000 Babies May Be Saved Each Year” announced an attack on infant mortality by the newly created United States Children’s Bureau (USCB).1 Fought for by progressive reformers, promoted by President Theodore Roosevelt, supported by pediatricians, and signed into law by President William Howard Taft, the USCB is now celebrating its 100th anniversary. Its mission, to investigate and report on all matters pertaining to children and child life, marked a bold step for the federal government, which until that time left health policy to state and local governments. The USCB was created when infant deaths were common, the promise of science seemed bright, and pediatrics was emerging as a specialty in the United States. Tracing the history of the USCB reveals some origins of the fault lines that continue to characterize pediatric medicine today.

In 1912, the infant mortality rate (IMR) in the United States was more than 100 per 1000 live births. Infectious diseases, poor nutrition, and unsafe labor practices threatened children of all ages. Understandably, reformers and political leaders expressed concern; they recognized the IMR as a critical measure of the economic status of a community and knew the nation’s future rested on the healthy development of children. The fewer than 100 physicians who specialized in children joined a broad coalition of medical and lay health advocates to address the social and biological determinants of infant and child health through improvements to the environment, laws mandating pasteurization of milk, public understanding of the germ theory, research on links between poverty and illness, and an attack on the...
gastrointestinal and respiratory diseases responsible for most infant deaths.\textsuperscript{2,3} USC\textsuperscript{4} Director Julia Lathrop argued that a better understanding of the IMR was critical to improve child health, and, under her leadership, the USC\textsuperscript{4} conducted a series of fine-grained studies in 8 communities throughout the nation. These models of public health research proved crucial in identifying social and individual factors for infant deaths, and together provided powerful testimony about the hardships facing many families. For example, a 1919 study of 433 families working in the oyster- and shrimp-canning industries of the Gulf Coast described a mother who appreciated the “clean cement” where she left her infant while she worked, and another mother glad to leave her 7-month-old daughter lying in a cradle at the factory rather than at home with her 8-year-old brother where “the mosquitoes would eat her up.”

Pediatricians supported USC\textsuperscript{4} programs and served as crucial allies of child welfare reformers in the early 20th century; however, this period also marks the beginning of a deep ambivalence toward government health programs. Initially, practitioners saw no conflict between clinical medicine provided to individual patients and public health advocacy on behalf of women and children. As USC\textsuperscript{4} programs expanded to include direct provision of medical care, however, they met with the hostility of organized medicine, especially the American Medical Association (AMA).

In the 1920s, many pediatricians supported the USC\textsuperscript{4}’s proposal to promote maternity and child care through a program of matching funds to the states, which became known as the Sheppard-Towner Act of 1921. The Act stimulated states to distribute educational materials, open well-child clinics, send out personalized prenatal letters, and hire visiting nurses, especially in rural and underserved areas. Testifying before a committee of the House of Representatives, Columbia University pediatrician Philip Van Ingen spoke favorably about the work of the USC\textsuperscript{4} and conjectured that opposition from doctors would be small and short-lived.\textsuperscript{5} He was mistaken. Many physicians believed the USC\textsuperscript{4}-supported clinics, which functioned largely in an educational capacity, siphoned off paying patients. In fact, they referred those needing care to private physicians or health department services. Nevertheless, the AMA led the drive to allow the Act to expire in 1929; however, the Section of Diseases of Children within the AMA had endorsed the legislation and the disagreement led to the formation of the American Academy of Pediatrics (AAP) in 1930.

The relationship between the USC\textsuperscript{4} and organized medicine grew even more antagonistic during World War II. The USC\textsuperscript{4} dispersed funds for the Emergency Maternity and Infant Care (EMIC) program, which paid for medical, hospital, and nursing care for the wives and infants of servicemen in the lowest 4 pay grades. The AMA vehemently opposed the program as a step toward “socialized medicine.” When the USC\textsuperscript{4} proposed extending the EMIC program after the war, the AAP also issued a statement condemning the measure, although many prominent pediatricians continued to support the USC\textsuperscript{4}. Nevertheless, in the post–World War II years, Congress limited the USC\textsuperscript{4}’s work to research and education, despite evidence that direct services, such as visiting nurses funded by the Sheppard-Towner Act, had a greater impact on the IMR.\textsuperscript{6}

The AAP’s stance on the EMIC program reflected the dominant trend in American medicine from the mid- through the late-20th century, which favored the provision of scientifically based health care in hospitals and doctor’s offices rather than in community settings. Collaborations with community partners were viewed as appropriate for public health officials, who, organized medicine demanded, should refrain from providing medical care to individual patients.\textsuperscript{2,8} Private practitioners, meanwhile, focused on providing high-quality clinical care to 1 patient at a time.

Despite its diminished role, the legacy of the USC\textsuperscript{4} lives on in the maternal and child health and welfare provisions of the Social Security Act of 1935, which remains the basis for most state and federal child health programs.\textsuperscript{9} Today it resides within the Department of Health and Human Services, Administration on Children, Youth and Families, and “partners with federal, state, tribal and local agencies to improve the overall health and well-being of our nation’s children and families.”\textsuperscript{10}

The history of USC\textsuperscript{4} reminds us of the remarkable power of a society to act on behalf of its children in an organized fashion, and it also highlights the on-going challenge for child health professionals working with community partners to confront the current challenges of “millennial morbidity, characterized by differences in health outcomes linked to race and class.”\textsuperscript{11} Whether this challenge requires a reinvigorated USC\textsuperscript{4} with a broader mission and greater resources is something pediatricians and policymakers may wish to consider.

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